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No. 86-747

IN THE

Supreme Court of the United States

October Term 1986

STEPHEN B. HEINTZ, Commissioner of the Connecticut Department of Income Maintenance,

Petitioner,

against

DALE HILLBURN, by his parents and next friends Ralph and Eleanor Hillburn, *et al.*,

Respondents.

MOTION FOR LEAVE TO FILE BRIEF AS *AMICUS CURIAE* AND BRIEF OF *AMICUS CURIAE* CONNECTICUT ASSOCIATION OF HEALTH CARE FACILITIES, INCORPORATED IN SUPPORT OF THE COMMISSIONER'S PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

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Questions Presented

1. Under Title XIX of the Social Security Act (Medicaid), must termination of a provider agreement for deficiencies in quality of care be based on non-compliance with federal quality-of-care standards as determined by the state survey and certification agency?

2. Does Title XIX of the Social Security Act require the single state agency responsible for administration of the state's Medicaid plan to review the plan of care developed for each Medicaid patient by his or her personal physician in order to assess the adequacy of the plan itself?

3. Is the obligation of the single state agency to review the adequacy of care provided to Title XIX-assisted patients, and to take corrective action as needed, enforceable by a private cause of action pursuant to 28 U.S.C. § 1983?

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MOTION BY THE CONNECTICUT ASSOCIATION OF HEALTH CARE FACILITIES, INCORPORATED FOR LEAVE TO FILE BRIEF AS *AMICUS CURIAE* IN SUPPORT OF THE COMMISSIONER'S PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

The Connecticut Association of Health Care Facilities, Inc. ("CAHCF") hereby requests permission of this Court to file its brief as *amicus curiae* in support of the Petition of the Connecticut Commissioner of Income Maintenance for a Writ of Certiorari to the Second Circuit Court of Appeals. The Commissioner of Income Maintenance and New Brook Hollow Health Care Center, Inc. have consented to the filing of the brief. Letters from counsel for the Commissioner and for New Brook Hollow are filed together with this Motion. The named plaintiffs, Dale Hillburn, James Corbett, Sandra Fuchs, Stephen Kaplanka and Mark Kaplanka have withheld their consent. Therefore, CAHCF moves that leave to file a brief as *amicus curiae* be granted by this Court.

At issue in this case is the proper construction of provisions of Title XIX of the Social Security Act ("Medicaid"), 42 U.S.C. § 1396 *et seq.*, and regulations promulgated thereunder governing the basis for a state's termination of agreements with providers who render care and services to Medicaid-assisted patients. The Judgment of the District Court in this case requires the Connecticut Department of Income Maintenance ("CDIM") to terminate provider agreements with skilled nursing facilities ("SNFs"), under certain circumstances, based on reports of CDIM's Medical Review Teams regarding inadequate care. Termination is required even though the SNF has been and continues to be certified by the state's Certification Agency as being in compliance with all federal quality-of-care standards. It is the position of the Commissioner, and of CAHCF, that under the Act termination of provider agreements because of inadequate care must be based on the comprehensive review of compliance with federal health care standards conducted by the Certification Agency, not on reports of CDIM's Medical Review Teams.

CAHCF is a non-profit membership association of approximately one hundred seventy-five providers of health care services to patients in need of long-term nursing home care. Over ninety percent of its members are SNFs that have provider agreements with CDIM to render care and services to Medicaid-assisted patients and to receive payment for such care and services. All of these members are affected, actually or potentially, by the Judgment of the District Court. In addition, several hundred SNFs in states within the Second Circuit potentially are affected by that Court's affirmance of the Judgment. At least forty-nine states participate in the federal-state cooperative Medicaid program. If the holding of the Second Circuit is followed, the construction of the Act at issue in this case will affect thousands of providers throughout the country.

As a result of the Judgment, CAHCF's member SNFs are placed squarely in the midst of conflicting determinations by two state agencies. One, the Certification Agency, serves as the designee

of the Secretary of Health and Human Services in conducting reviews of compliance with the numerous and detailed federal health care standards (which include state licensure) called the Conditions of Participation. 42 U.S.C. § 1395aa(a); 42 C.F.R. § 405.1101-.1137; 42 C.F.R. § 405.1901 *et seq.* CDIM, through its Medical Review Teams, has the more limited responsibility of assessing the "adequacy of care" provided to individual Medicaid-assisted patients: no more specific standards for the Teams' reviews have been set forth either in statute or by regulation. 42 U.S.C. § 1396a(a)(31)(B); 42 C.F.R. § 456.610 *et seq.* Yet pursuant to the Judgment, the CDIM must terminate an SNF provider agreement on the basis of "inadequate" care, even though the SNF has been found by the Certification Agency to meet all of the Conditions of Participation.

The practical consequences of termination of a provider agreement are devastating. In Connecticut, approximately sixty-five percent of SNF residents receive Medicaid assistance. Termination of a Medicaid provider agreement therefore will result in at least substantial economic loss to and, in most cases, the forced closing of the facility. Termination also requires the transfer of all Medicaid-assisted patients. To permit such results to arise from the findings of the Medical Review Teams is inconsistent with the states' sound and efficient administration of their Medicaid programs and the purposes and policies underlying the Act.

It is important that the consequences of the District Court's Judgment be considered from the perspective of the SNFs participating in the Medicaid program. Although the Judgment imposes a heavy administrative burden on the CDIM, its impact will be most fully and severely experienced by providers. Therefore, CAHCF urges this Court to consider the views of its member health care providers in its decision regarding review.

Conclusion

Because CAHCF has a substantial interest in this case and because its brief will provide a perspective on the issue before this Court that supplements the concerns expressed by the CDIM, this motion for leave to file its brief as *amicus curiae* should be granted.

Respectfully submitted,

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Statement of Interest and Summary of Argument

A. Statement of Interest

The Connecticut Association of Health Care Facilities, Inc. ("CAHCF") is a non-profit membership association of approximately one hundred seventy-five providers of health care services to patients in need of long-term nursing home care. Over ninety percent of its members are skilled nursing facilities that have entered into agreements ("provider agreements") with the State of Connecticut Department of Income Maintenance ("CDIM") to provide care and services to patients receiving assistance under Title XIX of the Social Security Act and to receive payment from CDIM for such care and services. All of these members are affected, actually or potentially, by the Order of the District Court

requiring CDIM to terminate provider agreements,[1] under certain circumstances, based on reports by CDIM's Medical Review Teams. In order to understand the interest of CAHCF's member facilities in this matter, one must first understand the statutory and regulatory framework governing quality-of-care determinations and termination of provider agreements.

1. CDIM, the "single state agency."

Title XIX of the Social Security Act ("Medicaid"), 42 U.S.C. § 1396 *et seq.*, is a cooperative federal-state program designed to assist eligible individuals with the cost of necessary medical services. Each state participating in the Medicaid program must designate a single state agency—in Connecticut, the Department of Income Maintenance ("CDIM")—as responsible for the general administration of its Medicaid plan. 42 U.S.C. § 1396a (a)(5).

2. Certification Agency.

In addition to the single state agency, the state must designate a *separate* state agency—in Connecticut, the Connecticut Department of Health Services ("Certification Agency")—as responsible for the oversight of health care standards in institutions serving Medicaid patients. 42 U.S.C. § 1396a(a)(9)(A).

This state health agency must be the same agency designated by the Secretary of Health and Human Services (the "Secretary") under Title XVIII of the Social Security Act ("Medicare") to inspect the adequacy and quality of institutional care and to certify institutional providers as eligible for participation in the Medicare program. 42 U.S.C. § 1395aa(a); 42 U.S.C. § 1396a(a)(9)(A);

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[1]CAHCF has chosen to address fully only the first of the three Questions presented as that Question most directly affects its members. CAHCF also supports the Petitioner's request for review of the second and third Questions presented but believes the reasons for requesting review are addressed adequately in the Petitioner's Brief.

42 C.F.R. § 405.1901 *et seq.;* 42 C.F.R. § 431.610(b). The Certification Agency also performs the survey and certification function for purposes of the Medicaid program. 42 U.S.C. § 1396a(a)(33)(B); 42 C.F.R. § 431.610(b) and (e). Institutional providers who are certified as eligible by the Certification Agency may enter into Medicare provider agreements with the Secretary and Medicaid provider agreements with the single state agency (here, CDIM) in order to receive payments under these programs. 42 U.S.C. § 1395cc(a); 42 U.S.C. 1396i; 42 C.F.R. § 442.10 *et seq.*

3. Skilled Nursing Facility ("SNF").

SNFs are one type of long-term care provider that may be certified by the Certification Agency. The quality-of-care standards for certification as an SNF under Medicare and Medicaid are identical. Under both programs, in order to enter into a provider agreement, an SNF must comply with the comprehensive quality-of-care standards called Conditions of Participation. 42 U.S.C. § 1395x(j)(15); 42 U.S.C. § 1396a(a) (28); 42 C.F.R. § 405.1101-.1137; 42 C.F.R. § 431.610(f)(1). An SNF that has been certified by the Certification Agency as eligible to participate in Medicare is automatically eligible to participate in Medicaid.[2] 42 U.S.C. § 1396i; 42 C.F.R. § 442.12(a).

4. Conditions of Participation.

The Certification Agency conducts exhaustive on-site inspections on at least an annual basis for the purpose of certifying whether an SNF meets the federal Conditions of Participation for Medicare and Medicaid. 42 C.F.R. § 405.1902-.1904; 42 C.F.R.

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[2]In the case of Intermediate Care Facilities and the very small number of SNFs that have Medicaid but not Medicare provider agreements, the Certification Agency certifies eligibility for payment directly to the single state agency. 42 C.F.R. § 442.101(a) and (c). Virtually all of CAHCF's member SNFs have both Medicaid and Medicare provider agreements and are subject to dual certification.

§ 431.610. The Conditions, which set precise standards for all areas of institutional functioning and patient care, include 87 "Standards," which have been further subdivided into several hundred "Factors."[3] 42 C.F.R. § 405.1101-.1137; HCFA Survey Forms 519 and 525. These separate Factors are addressed by the Certification Agency during the inspection process. In certifying a facility, the Certification Agency also must consider the supplemental reports of CDIM's Medical Review Teams (see page 5 *infra*) and any other reports pertaining to the health and safety of patients. 42 C.F.R. § 405.1904(b)(2) and (3); 42 C.F.R. § 431.610(g)(1)(i).

5. Sanctions triggered by the Certification Agency report.

If at any time the Certification Agency finds that a facility does not meet the requirements for certification, it must notify the Secretary. 42 C.F.R. § 405.1905(a). The Secretary may then: (a) continue the provider agreement on a conditional basis; (b) deny payment for new admissions; or (c) terminate the provider agreement. 42 U.S.C. § 1395cc(f)(1); 42 C.F.R. § 405.1908. Sanctions imposed on the provider under Medicare are automatically imposed under Medicaid. Thus, any conditions imposed by the Secretary on a Medicare provider agreement must be imposed by CDIM on that provider's Medicaid agreement; a denial of Medicare payments for new admissions requires a cor-

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[3]"Conditions" designate broad areas of institutional and patient care functions and services, *e.g.*, "Nursing Services," "Specialized Rehabilitative Services," "Infection Control." *See* 42 C.F.R. §§ 405.1124; 405.1126; 405.1135. "Standards" set forth requirements that must be implemented by SNFs in order to comply with the Conditions. For example, the Specialized Rehabilitative Services Condition sets forth the services that must be offered; the relevant Standards contain requirements regarding staffing, written plans of care, progress reports and documentation. *See* 42 C.F.R. §§ 405.1126; 405.1126(a), (b) and (c). "Factors" are the specific items that must be addressed by the Certification Agency surveyors in the course of their inspections. The HCFA Survey Forms 519 and 525, which list over seven hundred Factors, are eighty-three pages long and therefore have not been reproduced as an appendix to this Brief.

responding denial of Medicaid payments; and termination of a Medicare provider agreement automatically results in termination of the facility's Medicaid provider agreement. 42 U.S.C. § 1395cc(f)(1)(B); 42 U.S.C. § 1396i; 42 C.F.R. § 442.12(a) and (c).

6. CDIM's Medical Review Teams.

The adequacy of care provided to Medicaid-assisted patients is also subject to supplementary oversight by CDIM's Medical Review Teams, which conduct periodic inspections of the adequacy of services available to meet the health needs of these patients. 42 U.S.C. § 1396a(a)(31)(B); 42 C.F.R. § 456.610 *et seq*. Their inspections include observing patients and reviewing their medical records. 42 C.F.R. § 456.608. The Teams must submit reports, including their observations, conclusions, and recommendations, to CDIM, which must forward copies of the reports to the Certification Agency. 42 C.F.R. § 456.611-.612. These supplemental reports are then considered by the Certification Agency (and, through it, by the Secretary) in determining whether to continue or terminate the facility's provider agreement. 42 C.F.R. § 405.1904(b)(2) and (3); 42 C.F.R. § 431.610(g)(1)(i).

The Judgment of the District Court in this case requires CDIM, under certain circumstances, to terminate Medicaid provider agreements solely on the basis of reports of these Medical Review Teams, even though the provider continues to be certified by the Certification Agency as being in compliance with all relevant federal standards and eligible to participate in the Medicaid program. Appendix to Petitioner's Brief at 84A.[4] Thus CAHCF's member SNFs are placed squarely in the midst of potentially conflicting determinations by CDIM and the Certification Agency.

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[4]Citations to the Decisions of the District Court and the Court of Appeals and to the Judgment of the District Court will be by reference to the Appendix submitted with the Commissioner's Petition for a Writ of Certiorari.

Because the Certification Agency simultaneously serves as the designee of the Secretary of Health and Human Services, the Judgment also implicates the role of the federal government and the supremacy of federal quality-of-care standards used in certifying the eligibility of providers for jointly-funded health care programs.

In addition, the practical consequences of termination of a Medicaid provider agreement are severe. Approximately sixty-five percent of the patients residing in skilled nursing facilities in Connecticut receive Medicaid assistance. Termination of a Medicaid provider agreement will result in substantial economic loss and, in most cases, the forced closing of the facility. Termination also requires the transfer of all of the facility's patients receiving Medicaid assistance.

For all of these reasons, the Judgment of the District Court is of vital concern to the member facilities of CAHCF. Therefore, CAHCF submits this Brief in support of the Petition of the Commissioner of Income Maintenance for a Writ of Certiorari to the Second Circuit Court of Appeals.

B. Summary of Argument

The central issue in this case is whether the Medicaid Act and its regulations require that termination of a Medicaid provider agreement for deficiencies in quality of care must be based on non-compliance with federal quality-of-care standards as determined by the Certification Agency. Put another way, the question is whether CDIM can be required or even authorized by a court to terminate provider agreements based solely on the findings by CDIM's Medical Review Team of inadequate care with respect to individual Medicaid-assisted patients.

The statute and regulations make clear that Congress intended to vest authority for monitoring compliance with the comprehensive federal standards governing quality of care in the Certification Agency, which serves as the designee of the Secretary

of Health and Human Services. It is the Certification Agency, applying federal standards, which makes the determination of whether a facility has met the quality-of-care standards required for continued participation in Medicare and Medicaid. The Judgment in this case, requiring CDIM to terminate provider agreements on the basis of Medical Review Team reports alone, violates the established statutory and regulatory scheme. It places state agencies in conflict with each other and the state in conflict with the federal government, all contrary to the purposes and policies underlying the Act.

Moreover, the District Court violates established principles of comity and federalism by imposing upon CDIM the obligation to terminate provider agreements on the basis of Medical Review Team reports even though no such obligation is contained in the Social Security Act. Indeed, the District Court and the Court of Appeals based this obligation upon an interpretation of the Act derived from isolated provisions, phrases and a single disjunctive contained in the regulations. This Court has held that, in cooperative federal-state programs enacted by Congress pursuant to its spending power, Congress may not impose funding obligations upon the states that are not clearly expressed by statute. *Pennhurst State School & Hospital* v. *Halderman,* 451 U.S. 1, 17 (1981). Even though the obligation imposed in this instance is not primarily a funding obligation, the Second Circuit's construction of the Act and relevant regulations is equally disruptive to the states' administration of their Medicaid programs and is equally inconsistent with fundamental principles of comity and federalism. For all of the foregoing reasons, this Court should review the District Court's grant of relief as affirmed by the Court of Appeals.

ARGUMENT

I. The Scope Of Relief As Affirmed By The Court Of Appeals Presents Questions Of Federal Law Of Vital Importance To The States Concerning The Appropriate Roles And Obligations Of State Agencies In The Cooperative Federal-State Program Established Pursuant To Title XIX Of The Social Security Act.

A. The Requirement That The Single State Medicaid Agency Must Terminate Provider Agreements Based On Findings Of Its Medical Review Teams Is Unauthorized By The Act And Disruptive Of The Sound And Efficient Administration By The States Of Their Title XIX Programs.

This case is a class action brought by severely disabled residents of SNFs in Connecticut who receive assistance with payment for the cost of their care from both the federal and state governments under the provisions of Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.* The plaintiffs sought injunctive relief requiring the Connecticut Commissioner of Income Maintenance to provide them with specially adapted wheelchairs and related services, including assessment of each individual's need for such a wheelchair and training in its safe and adequate use. App. at 40A.

In the course of its decision, the District Court held that CDIM's Medical Review Teams are required to review the adequacy of the care received by each Medicaid-assisted patient. App. at 64A. The Court then noted 42 C.F.R. § 456.613, which requires CDIM to take "corrective action as needed" based on the report of the Medical Review Team, and held that "corrective action" must be construed to include termination of the Medicaid provider agreement. App. at 66A. It is this holding that conflicts with the overall scheme of the Social Security Act. Congress has clearly articulated that termination of Medicaid provider agreements on grounds of deficient health care can occur only when the Certifi-

cation Agency finds that a facility has failed to comply with federally-mandated quality-of-care standards.

The Judgment not only undermines the authority of the Certification Agency and the Secretary, it also imposes upon the states obligations which Congress did not intend and disrupts the states' sound and efficient administration of their Medicaid programs. In affirming the Judgment, the Court of Appeals improperly relied upon isolated provisions of disparate regulations, including the termination for "good cause" provision of 42 C.F.R. § 442.12(d) and a single disjunctive used in 42 C.F.R. § 431.151. App. at 22A-23A. Such an approach to statutory construction has been rejected by this Court, which has held that "[i]n expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy." *Philbrook* v. *Glodgett*, 421 U.S. 707, 713 (1975), quoting *United States* v. *Heirs* of *Boisdoré*, 49 U.S. (8 How.) 113, 122 (1850).

By viewing the statutory and regulatory scheme as a whole, the Court of Appeals' error is apparent.

First, the Act creates a structure under which the Certification Agency, not CDIM or its Medical Review Teams, is responsible for the maintenance of quality-of-care standards for Medicaid-assisted patients. 42 U.S.C. § 1396a(a)(9)(A). These quality-of-care standards are set forth in elaborate detail in the comprehensive regulations promulgated by the Secretary known as the Conditions of Participation. 42 C.F.R. § 405.1101-.1137. All Medicare and Medicaid providers must comply with these standards in order to enter into and to continue provider agreements. 42 U.S.C. § 1395x(j)(15); 42 U.S.C. § 1396a(a)(28); 42 C.F.R. § 405.1901 *et seq.*; 42 C.F.R. § 431.610(f)(1).

Second, regulations promulgated by the Secretary under the Act specifically designate the Certification Agency as the sole agency responsible for determining whether providers have met

these requisite Conditions. 42 C.F.R. § 405.1902-.1904; 42 C.F.R. § 431.610(b) and (e). It is the Certification Agency, not CDIM's Medical Review Teams, which conducts the in-depth, detailed and comprehensive on-site inspections required to make this determination. *Id.* As a result of these inspections, the Certification Agency decides whether it will certify to the Secretary that a facility is eligible to participate in Medicare or Medicaid. 42 C.F.R. § 405.1902; 42 C.F.R. § 431.610(b).

Third, the Act and regulations make clear that decisions to impose sanctions on providers for failure to meet quality-of-care standards must be based on the exhaustive review performed by the Certification Agency, not on the more superficial inspections performed by CDIM's Medical Review Teams. Termination of a provider agreement by the Secretary is based on his determination that the facility has not met the Conditions of Participation. 42 U.S.C. §1395cc(b)(2)(A) and (B); 42 U.S.C. § 1395cc(f). Only the Certification Agency is designated by the Secretary to assess compliance with these Conditions. 42 U.S.C. § 1395aa(a). Termination of the Medicare provider agreement by the Secretary effectively causes the termination of an SNF's Medicaid provider agreement as well. *See* 42 U.S.C. § 1396a(a)(28); 42 U.S.C. § 1396i(c); 42 C.F.R. § 442.12(a) and (c); 42 C.F.R. § 442.117. Similarly, if the Secretary decides to impose the alternative sanction of a limitation on admissions, he will order CDIM to deny Medicaid payments for new admissions. 42 U.S.C. § 1395cc(f)(1)(B). All of these consequences flow directly from the assessment of compliance made by the Certification Agency.[5] *See* 42 U.S.C. § 1395aa(a); 42 C.F.R. § 405.1901 *et seq.*

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[5]In the very rare instances of SNFs that have only Medicaid provider agreements and in the case of Intermediate Care Facilities, certification is made directly to CDIM by the Certification Agency. 42 C.F.R. § 442.101(a) and (c). In these instances, CDIM's authority to terminate an agreement is clear; however, the basis for the determination remains the detailed quality-of-care review conducted by the Certification Agency, not reports by the Medical Review Team standing alone.

In view of this tightly structured statutory and regulatory scheme, the reliance of the lower courts on the "good cause" exception for termination by CDIM is misplaced. App. at 23A, 63A. By focusing on 42 C.F.R. § 442.12(d) alone and out of context, the lower courts erroneously concluded that this provision allowed CDIM to terminate provider agreements solely on the basis of reports from the Medical Review Teams. This simplistic analysis usurps the role of the Certification Agency which, with its detailed quality-of-care reviews, is the agency Congress entrusted with assessing the need for termination of agreements with facilities providing substandard care. Significantly, Medicare and Medicaid providers are subject to numerous requirements in addition to the fundamental requirement of compliance with the federal Conditions of Participation, *e.g.*, fraud and abuse and civil rights provisions. *See, e.g.*, 42 U.S.C. § 1320a-3; 42 U.S.C. § 1320a-5; 42 U.S.C. § 1320a-7; 42 U.S.C. § 1395cc(a)(1); 42 C.F.R. § 489.10 *et seq.*; 42 U.S.C. 1396a(a)(32), (35), (38) and (39); 42 U.S.C. § 1396h; 42 C.F.R. § 442.13-.14. Under the similar "good cause" exception governing Medicare providers, the reasons for termination are specified as fraud and abuse, failure to disclose ownership and control interests, bankruptcy or insolvency, and failure to comply with civil rights requirements. 42 C.F.R. § 489.12. There is no basis for construing the Medicaid "good cause" exception contained in §442.12 (d) more broadly.

Fourth, in contrast to the well-established role of the Certification Agency, the role of CDIM's Medical Review Teams in assessing quality of care is subordinate and sharply limited.

By statute, Medical Review Teams (called "professional review teams" in the Act) are charged with inspecting "the adequacy of the services available to meet [the individual patient's] current health needs and promote his maximum physical well-being."[6] 42 U.S.C. § 1396a(a)(31)(B)(i). The regulations gov-

[6]The Teams also review the necessity for institutionalization and the fea-

(Footnote continued on following page)

erning the Medical Review Teams do not set forth specific standards but instead provide that the Teams must determine whether services are adequate to "[m]eet the health needs of each recipient . . . and . . . [p]romote his maximum physical, mental, and psychosocial functioning." 42 C.F.R. § 456.609(a)(1) and (2). In making this determination, the Teams should observe:

"(1) Cleanliness;
(2) Absence of bedsores;
(3) Absence of signs of malnutrition or dehydration; and
(4) Apparent maintenance of maximum physical, mental and psychosocial function."

42 C.F.R. § 456.610(e). It is apparent that the type of inspection conducted by the Teams is substantially less detailed than that performed by the Certification Agency, which must address and determine compliance with the seven hundred separate Factors included in the eighteen comprehensive Conditions of Participation.

The Medical Review Teams must make reports, including recommendations, to CDIM. 42 C.F.R. § 456.611. CDIM in turn is required to forward a copy of each report to the Certification Agency. 42 C.F.R. § 456.612(c). The Certification Agency is required to review and consider these supplemental reports as part of its assessment of whether a facility is qualified to participate in Medicare and Medicaid. 42 C.F.R. § 405.1904(b)(2) and (3); 42 C.F.R. § 431.610(g)(1)(i). These regulations

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sibility of noninstitutional care. 42 U.S.C. § 1396a(a)(31)(B)(ii) and (iii). While these Teams assess patient care, the evaluation is principally to determine whether the care actually given is commensurate with the patient's physical condition and level of classification, *i.e.*, skilled nursing care or intermediate care. 42 C.F.R. § 456.609-.611. The determination of appropriate levels of care has reimbursement implications for the provider for which CDIM, as the single state agency, has primary responsibility. 42 U.S.C. § 1396a(a)(5).

make clear that the Teams' role is subordinate to that of the Certification Agency and that any decision to terminate a provider agreement based on the Teams' report must be made through that Agency.

Although CDIM is required by regulation to take "corrective action as needed" based on the Teams' reports, 42 C.F.R. § 456.613, that phrase is not defined and cannot properly be construed in isolation apart from the entire statutory and regulatory framework. The Act and regulations clearly require that decisions regarding provider terminations based on quality of care originate with the comprehensive assessment conducted by the Certification Agency. Any construction of the phrase "corrective action as needed" that includes provider terminations based on the Teams' findings alone is erroneous. Reports of Medical Review Teams may furnish part of the basis for the Certification Agency's assessment, but CDIM cannot act on these reports independently, in derogation of the authority vested by Congress in the Secretary and the Certification Agency.

The specific language of the statute and regulations also is instructive with regard to the appropriate role of the Medical Review Teams. The function of the Teams is to determine whether available services are "adequate to . . . [m]eet the health needs of each recipient . . . and . . .[p]romote his maximum physical, mental, and psychosocial functioning." 42 C.F.R. § 456.609(a)(1) and (2). *See also* 42 U.S.C. § 1396a(a)(31)(B)(i). This Court repeatedly has held, especially in the context of cooperative federal-state programs, that such language cannot be read as prescribing substantive standards but instead indicates goals and objectives. For example, in *Pennhurst State School & Hospital* v. *Halderman,* 451 U.S. 1 (1981), this Court refused to construe the language of 42 U.S.C. § 6010 describing "appropriate treatment, services and habilitation . . . designed to maximize the developmental potential of the person" as creating rights to specific kinds of treatment. 451 U.S. at 27. Similarly, in *Alexander* v. *Choate,* 469 U.S. 287 (1985), the Court held that the phrase

"adequate health care" could not be construed to require that Medicaid patients receive specific benefits precisely tailored to their individual needs. 469 U.S. at 302-03.

In its Judgment, the District Court appears to have assumed that the statute and regulations governing Medical Review Teams set forth standards which would furnish a separate basis for termination of provider agreements. However, in accordance with the principles set forth in *Pennhurst* and *Alexander*, the language of the statute and regulations cannot properly be construed to reach such a result. At least to the extent that the Judgment implies the existence of such standards, it is inconsistent with the holdings of this Court cited above.

The statute and regulations, construed as a whole and in accordance with prior holdings of this Court, make clear that reports of Medical Review Teams in themselves cannot furnish the basis for termination of provider agreements. Assessment of compliance with federal quality-of-care standards is committed to the Certification Agency and any termination of a provider agreement based on failure to comply with these standards must flow from the Certification Agency's determinations. This interpretation permits the complementary co-existence of the Medical Review Team and the Certification Agency that is essential to the sound and efficient administration by the states of their Medicaid plans.

If the affirmance by the Court of Appeals of the scope of relief granted by the Judgment is allowed to stand, the conflicting roles of CDIM and the Certification Agency may result in contradictory determinations disruptive of federal-state relations and the harmonious functioning of the states' programs. The interpretation of the statute and regulations by the District Court and the Court of Appeals is inconsistent with the integrated statutory scheme and with the Secretary's own regulations. These important inconsistencies in the construction of a wide-reaching federal law should be reviewed by this Court.

B. The Scope Of Relief Granted In This Case Conflicts With Prior Decisions Of This Court Holding That Obligations Imposed On The States By Congress Through Legislation Enacted Pursuant To Its Spending Power Must Be Affirmatively And Unambiguously Expressed.

Title XIX appropriates federal funds "[f]or the purpose of enabling each State . . . to furnish (1) medical assistance on behalf of [certain classes of persons], whose income and resources are insufficient to meet the cost of necessary medical services, and (2) rehabilitation and other services to help [these persons] attain or retain capability for independence or self-care." 42 U.S.C. § 1396. The Medicaid program has been described by this Court as a program of "cooperative federalism." *King* v. *Smith*, 392 U.S. 309, 316 (1968). In such cooperative programs, the federal government can impose on the states only those obligations which Congress clearly intended to impose. Attempts to impose broader obligations are barred by the principles of comity and federalism.

In *Pennhurst State School & Hospital* v. *Halderman*, 451 U.S. 1 (1981), this Court addressed certain provisions of the Developmentally Disabled Assistance and Bill of Rights Act, a federal statute "designed as a cooperative program of shared responsibilit[ies]" similar in structure and intent to the Medicaid statute. 451 U.S. at 22. In construing the obligations of the states to provide particular kinds of treatment and services under the Act, the Court found that

> legislation enacted pursuant to the spending power is much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions. The legitimacy of Congress' power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.' There can, of course, be no knowing acceptance if a State is unaware of the conditions or is unable to ascertain what is expected of it. Accordingly, if Congress intends to impose a

> condition on the grant of federal money, it must do so unambiguously.

451 U.S. at 17 (citations omitted). *See also Board of Education v. Rowley*, 458 U.S. 176, 204 n.26 (1982).

The relief granted by the District Court in this case construes Title XIX of the Social Security Act as requiring CDIM to terminate provider agreements based on findings made by its Medical Review Teams alone. This construction is not based on any unambiguous requirement of the Act, but instead is based on isolated phrases and a single disjunctive contained in regulations. For example, the Court of Appeals cited the disjunctive contained in 42 C.F.R. § 431.151 as evidence that a provider agreement may be terminated even though the facility continues to be certified by the Certification Agency as complying with all conditions and standards governing quality of care. This takes § 431.151, which is a *procedural* regulation granting no substantive authority, completely out of context.

In no instance did the Court of Appeals cite any unambiguously expressed provision of the statute or, indeed, any provision of the statute, as the basis for its affirmance of the obligations imposed by the District Court. Instead, it concluded only that the relief ordered by that Court was "not precluded" by the Act. App. at 24A.

As set forth in Section I. *supra*, the District Court's imposition on CDIM of an obligation to terminate provider agreements solely on the basis of Medical Review Team reports is unauthorized by the statute. The obligation in this case is not primarily an obligation to fund particular services, such as the plaintiffs in *Pennhurst* sought to impose. Nevertheless, the District Court's Judgment is equally disruptive to the sound administration by the states of their Medicaid programs and equally inconsistent with fundamental principles of comity and federalism. The Judgment in this case should be reviewed by this Court because it conflicts

with the holding of *Pennhurst* and does violence to the federal statutory scheme governing quality-of-care reviews and provider eligibility to participate in the Medicaid program.

Conclusion

Because the Judgment of the District Court violates the comprehensive statutory scheme governing compliance with federal health care standards set forth in Titles XVIII and XIX of the Social Security Act, and conflicts with prior holdings of this Court, the Connecticut Association of Health Care Facilities, Inc. joins the Connecticut Commissioner of Income Maintenance in respectfully requesting review of the Judgment by this Court.

Respectfully submitted,

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